

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  44A122	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED  11/22/2010
NAME OF PROVIDER OR SUPPLIER  PAVILION, THE CPC			STREET ADDRESS, CITY, STATE, ZIP CODE 1406 MEDICAL CENTER DRIVE LEBANON, TN 37087		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the corridor doors.</p> <p>The findings include:</p> <p>Observation of the Resident room 113 on 11/22/10 at 7:50 AM, revealed the door was being held open with a trash can. National Fire Protection Association (NFPA) 101, 7.2.1.5.4</p> <p>This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10.</p>	K 018	<p>a. The trashcan was immediately moved away from the door to another location in room 113.</p> <p>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director has inspected all doors in the facility to know their current condition and whether they open, close, and remain open as desired without having an impediment.</p> <p>c. Staff was inserviced on 11/29/10 by Administrator on the importance of not propping doors open or using impediments of any kind.</p> <p>d. The Maintenance Director will audit for these practices during his observation rounds of facility. Doors that were identified as closing on their own will be realigned and adjusted by Isenhour Door Company on or before 12/16/10.</p>	12/18/10	
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*G. Ray Lane, NHA*

*Administrator*

*12/3/10*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029 SS=D	Continued From page 1  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the hazardous areas.  The findings include:  Observation of the attic mechanical room on 11/22/10 at 8:13 AM, revealed a penetration in the wall. National Fire Protection Association (NFPA) 101, 19.3.2.1  This findings was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10.	K 029	a. The penetration was filled with fire caulk by the Maintenance Director on 11/24/10. b. All residents have the potential of being affected by the deficient practice. The Maintenance Director and Administrator have surveyed the facility for any other penetrations to fill with fire caulk or drywall mud. c. The staff will communicate any penetration findings within the facility to the Maintenance Director via work orders as instructed in inservice on 11/30/10 by the Maintenance Director. d. The Maintenance Director will look at all walls and ceilings for penetrations during weekly preventative maintenance rounds and will report to the Administrator any findings.	11/26/10	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052			

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K 052	Continued From page 2  This STANDARD is not met as evidenced by: Based on record review on 11/22/10 at 9:00 AM, it was determined the facility failed to maintain the alarm system.  The findings include:  Record review on 11/22/10 at 9:00 AM, revealed no annual testing was conducted on the alarm system. National Fire Protection Association (NFPA) 72, 7-3.1  This findings was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. NFPA 101 LIFE SAFETY CODE STANDARD	K 052	a. The annual testing of the alarm system was completed on 11/22/10 by ADT. b. All residents have the potential of being affected by the deficient practice. The Maintenance Director will review the log of annual inspections to make sure all inspections/tests are complete. c. The Maintenance Director has a log for annual inspections or tests that are to be completed. He will monitor this log monthly to assure no annual inspections or tests will be missed. d. The Administrator will monitor the annual log monthly to maintain accountability of these practices.		11-23-10 11/23/10 Per Phone Consent
K 054 SS=E	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  This STANDARD is not met as evidenced by: Based on record review it was determined the facility failed to maintain the smoke detectors.  The finding include:  Records review on 11/22/10 at 9:15 AM, revealed	K 054			

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K 054	Continued From page 3 no semi or annual inspection of the smoke detectors. National Fire Protection Association (NFPA) 72, 3.2.3  This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10.	K 054	a. The inspection of the smoke detectors was completed on 11/29/10 by D&H Electronics.		11/29/10
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on records review it was determined the facility failed to maintain the sprinkler system.  The findings include:  Records review on 11/22/10 at 8:10 AM, revealed no quarterly testing was conducted on the sprinkler system. National Fire Protection Association (NFPA) 25  This finding was acknowledged by the Administrator and verified by the Director of	K 056	b. All residents have the potential of being affected by the deficient practice. The Maintenance Director will review the annual log to make sure all inspections and/or tests are complete. c. We will add a log for the inspection of the smoke detectors to be completed by an outside source annually. The Maintenance Director will monitor this log monthly and schedule all inspections when required. d. The Administrator will monitor the annual log monthly to maintain accountability of these practices.		

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K 054	Continued From page 3 no semi or annual inspection of the smoke detectors. National Fire Protection Association (NFPA) 72, 3.2.3  This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. NFPA 101 LIFE SAFETY CODE STANDARD	K 054			
K 056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on records review it was determined the facility failed to maintain the sprinkler system.  The findings include:  Records review on 11/22/10 at 8:10 AM, revealed no quarterly testing was conducted on the sprinkler system. National Fire Protection Association (NFPA) 25  This finding was acknowledged by the Administrator and verified by the Director of	K 056	a. A contract for quarterly tests to be conducted by Nashville Sprinkler Company was established on 11/30/10 with the first quarter test to be done on 1/11/11. The sprinkler system was tested on 10/14/10 to serve as its annual and fourth quarter test. b. All residents have the potential of being affected by the deficient practice. The Maintenance Director will review the quarterly log to make sure all inspections/ tests are complete. c. We will add a log for the sprinkler system to be completed quarterly by an outside source. The Maintenance Director will monitor this log and make sure all quarterly tests be completed by outside source in desired time. d. The Administrator will monitor the quarterly log monthly to maintain accountability of these practices.		11/30/10

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K 056	Continued From page 4	K 056			
K 064 SS=E	<p>Maintenance conference on 11/22/10.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the fire extinguishers.</p> <p>The findings include:</p> <p>(1) Observation of the attic on 11/22/10 at 8:15 AM, revealed the fire extinguisher in the front mechanical room was blocked with equipment. National Fire Protection Association (NFPA). 10, 1.6.3</p> <p>(2) Observation of the attic mechanical rooms and the fire alarm room on 11/22/10 at 8:17 AM, revealed fire extinguishers were not checked monthly. NFPA 10, 4.3.1</p> <p>These findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10.</p>	K 064	<p>a. The Maintenance Director checked and signed off on the fire extinguishers in the attic mechanical room and the fire alarm room on 11/22/10 to bring them current.</p> <p>b. All residents have the potential of being affected by the deficient practice. The Maintenance Director rechecked all fire extinguishers in the facility to make sure they were current.</p> <p>c. The Administrator has re-educated the Maintenance Director of all the fire extinguishers in the facility and what is required when checking them. We have provided a map of all fire extinguishers in the facility with a total number and require the maintenance director to account for all in the log. The Maintenance Director will follow his monthly log for fire extinguishers and sign off each fire extinguisher for that month.</p> <p>d. The Administrator will monitor the monthly log to keep accountability for these practices.</p>	<p>11-23-10 11/23/10 per phone conference</p>	
K 135 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for</p>	K 135			

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K 056	Continued From page 4	K 056			
K 064 SS=E	Maintenance conference on 11/22/10. NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the fire extinguishers.  The findings include:  (1) Observation of the attic on 11/22/10 at 8:15 AM, revealed the fire extinguisher in the front mechanical room was blocked with equipment. National Fire Protection Association (NFPA). 10, 1.6.3  (2) Observation of the attic mechanical rooms and the fire alarm room on 11/22/10 at 8:17 AM, revealed fire extinguishers were not checked monthly. NFPA 10, 4.3.1  These findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10.	K 064	a. The boxes were immediately moved away from the fire extinguishers in the front mechanical room on 11/22/10. b. All residents have the potential of being affected by the deficient practice. The Maintenance Director and Administrator have surveyed the facility and all fire extinguishers to make sure all fire extinguishers are clear of any blockages. c. We have moved all equipment or supplies away from fire extinguishers throughout the facility. We have marked around the fire extinguishers with red paint in the front mechanical room so staff will visually see not to place things in front of fire extinguishers. All staff was inserviced on 11/29/10 by the Administrator on importance of keeping all fire extinguishers clear of any blockages and the consequences that will occur if noncompliance is observed.	11/29/10	
K 135 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for	K 135	d. The Maintenance Director will monitor all fire extinguishers on a daily basis and will report any findings to the Administrator for disciplinary action.		

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K 135	Continued From page 5 flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.  This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the combustible liquids.  The findings include:  (1) Observation of the 200 and 300 hall clean supply rooms on 11/22/10 at 7:55 AM, revealed cylinders of oxygen were not secured. National Fire Protection Association (NFPA) 55, 6-6  (2) Observation of the maintenance shop on 11/22/10 at 8:12 AM, revealed a pressure washer (with gas in the tank) was stored in the room. NFPA 30, 4.4.3.6  These findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10.	K 135	a. The Maintenance Director immediately placed the unsecured oxygen cylinder into the properly secured area. b. All residents have the potential of being affected by the deficient practice. The Maintenance Director and Administrator surveyed the facility to make sure all oxygen cylinders are secure. c. As of 11/29/10, charge nurses will check oxygen cylinders at the beginning of each shift and sign off whether they are secure on the 24-hour report. d. The Director of Nursing will review each 24-hour report to make sure oxygen cylinders are remaining secured in supply rooms and will report any findings to the Administrator for disciplinary action.	11/29/10	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the electrical system.	K 147			

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K 135	Continued From page 5 flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.  This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the combustible liquids.  The findings include:  (1) Observation of the 200 and 300 hall clean supply rooms on 11/22/10 at 7:55 AM, revealed cylinders of oxygen were not secured. National Fire Protection Association (NFPA) 55, 6-6  (2) Observation of the maintenance shop on 11/22/10 at 8:12 AM, revealed a pressure washer (with gas in the tank) was stored in the room. NFPA 30, 4.4.3.6  These findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10. NFPA 101 LIFE SAFETY CODE STANDARD	K 135	a. The Maintenance Director immediately removed the pressure washer (with gas in the tank) and placed it in storage facility on 11/22/10. b. All residents have the potential of being affected by the deficient practice. The Maintenance Director reviewed the maintenance shop to remove any other equipment containing gas. c. The Maintenance Director will continue to monitor the facility for combustible liquids and will report to the Administrator any findings. d. The Administrator will continue to monitor the facility for combustible liquids and will administer corrective actions as needed.		11-23-10 11/23/10 Per Phon Concurrence
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the electrical system.	K 147			

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K 147	Continued From page 6 The findings include:  Observation of the kitchen dry storage room on 11/22/10 at 8:08 AM, revealed not all of the electrical outlets were ground fault circuit interrupters (GFCI) National Fire Protection Association (NFPA) 70, 517-20  This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 11/22/10.	K 147	a. The Maintenance Director changed the electrical outlets in the kitchen dry storage to ground fault circuit interrupters (GFCI) on 11/26/10. b. All residents have the potential of being affected by the deficient practice. The Maintenance Director and Administrator surveyed the rest of the Dietary Department to make sure all electrical outlets were ground fault circuit interrupters (GFCI). c. All outlets in the Dietary Department are ground fault circuit interrupters (GFCI). d. All outlets in the Dietary Department are ground fault circuit interrupters (GFCI).	11/30/10	